

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date
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☐ Refusal of admission until medically cleared

PATIE	ENT QUESTIONNAIRE (Explain all "Yes" answers)	Yes	No
1.	Who is your Primary Care Physician?		
2.	Have you ever or are you currently being treated for: asthma, diabetes, seizure disorder, thyroid disorder, heart condition, high blood pressure, bleeding disorder, liver disease or kidney disease? If yes, explain:	Y	N
3.	Have you or are you currently being treated for any other illness or health problem not listed above? If yes:	Y	N
4. Medic	Are you currently taking any medication prescribed to you by a physician? If yes, list: Cation(s) Name and Dose: Last Date Filled: Date Last Taken: (check only if applicable) Verified Not Verified HCP Notified Verified Not Verified HCP Notified	Y	N
5.	What pharmacy(s) do you use in what town(s)? List	Y	N
6.	Do you have any allergies to medications? : List:	Y	N
7.	Any other known allergies? List	Y	N
8.	Have you been hospitalized by a physician or psychiatrist? If yes, describe	Y	N
9.	Do you have current painful dental condition or dental complaint? If yes, describe		
10.	Have you been diagnosed with Hepatitis, venereal or sexually transmitted disease, HIV/ AIDS, or any other serious disease? If yes, list:		
11.	Have you ever had a positive TB skin test, been exposed to TB or been diagnosed with TB? If yes, When: Where:	Y	N
12.	Have you ever received treatment for exposure to or diagnosis of TB? If yes, where: When: Did you take medication? For how long? What was the name of the medication? Where/When was your last chest x- ray screening?	Y	N
13.	Do you currently have any of these symptoms: Persistent cough, shortness of breath, loss of appetite, fatigue, coughing up blood, night sweats or unexplained weight loss? If yes, explain:	Y	N



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14.	Are you on a specific diet prescrib	ped by a physician? If ye	s, explain:	-	Y	N		
15.	Do you have any history of an eat	ing disorder? List			_ Y	N		
16.	Mode of use? How much? How often? Last use?							
17.	Do you use alcohol? If yes, what How much?	t kind? Hov	v often?		Y	N		
18.	Do you have a history of withdraw	ral after you stopped usir	ng alcohol or drugs? If yes	s, describe:	Y	N		
19.	Have you ever had a seizure from	alcohol or drug withdrav	val? If yes, explain:		_ Y	N		
20.	O. Have you ever smoked cigarettes or used tobacco products? If yes, how many packs per day or how often? Is patient still smoking? Number of years as a smoker/tobacco user?							
21.	Have you ever received treatmen	t for substance or alcoho _When?	l abuse? If yes, Where:		Y	N		
22.								
	VISUAL OBSER	/ATION (Explain all "Ye	es" answers) Circle Y or	N	Yes	No		
23. If yes	3. Is Patient appearance abnormal in any way? (e.g., sweating, tremors, anxious, disheveled, unusually thin, evidence suggestive of trauma or abuse) f yes, describe:							
24.	Is Patient movement restricted or compromised in any way? (e.g., body deformities, physical abnormality, unsteady gait, cast or splint intake, etc.) If yes,							
25.	Is breathing abnormal? (e.g., pers	istent cough, hyperventil	lation, shortness of breath	, dyspnea, etc.)				



Does patient's skin or scalp have obvious lesions or draining wounds, lice or scabies, jaundice, rashes, bruises, edema, scars, tattoos, needle marks or other indications of drug abuse? If yes, explain:

Does Patient exhibit characteristics of potentially being at risk for victimization (e.g., age, small build,

femininity, 1st time offender, passive or timid appearance) If yes, explain:

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If yes, explain:

26.

27.



Pa	tient Name		Inmate Number	Bookir	ng Number	Date of Birth	Today's	Date	
REM	ARKS:					_	111		
Skin I	Exam / MRSA:								_
	ADA Form Comple	eted _	Reques	t Submitted					
	Education provided	d orally and in w	riting on Access to	o Healthcare	;				
	Education provided	d orally and in w	riting on Sexual A s	ssault Awar	eness				
Blood	Pressure Pulse	Respirations	Temp	O ₂ Sat	Peak Flow	Ht	l wt	BS	
Біоос	T dide	respirations	Temp	Ozout	T Car T TOW	111	***	100	
	u currently have Health Ii ☐ Yes ☐ N		ype: tate:						
		SUIC	IDE POTENTIAL	SCREENING				CIRC	LE
1	Arresting or transporting of	fficer believes sub	ject may be a suicide	e risk.				YES	NO
2	Lacks close family/friends	in community.						YES	NO
3	Worried about major proble	ems other than leg	gal situation (termina	l illness).				YES	NO
4	Family member or signification	ant other has atten	npted or committed s	suicide (spouse	e/parent/sibling/close	e friend/lover).		YES	NO
5	Has psychiatric history (ps							YES	NO
6	Holds position of respect in feelings of embarrassment		essional/public officia	al) and/or alleg	ed crime is shocking	g in nature. Expre	esses	YES	NO
7	Expresses thoughts about	killing self.						YES	NO
8	Has a suicide plan and/or	suicide instrument	in possession.					YES	NO
9	Has previous suicide atten	npt.						YES	NO
10	Expresses feelings there is	s nothing to look fo	orward to in the future	e (feelings of h	elplessness and ho	pelessness).		YES	NO
11	Shows signs of depression	(crying or emotio	nal flatness).					YES	NO
12	Appears overly anxious, at							YES	NO
13	Appears to feel unusually of							YES	NO
14	Is acting and/or talking in a		•	ion/hearing or	seeing things not th	ere).		YES	NO
15	Is apparently under the infl				:::			YES	NO
16	If YES to #15, is individual		wing signs of withdra	awai or mental	IIIness?			YES	NO
17 18	Is this individual's first arre		sing and Lot Power!	Offense	D Hoknows			YES	NO NO
10	Detainee's charges include	s. wurder, Klanapp	only and / or Sexual	Ollerise	Unknown			ILO	LINO
	diate Action: A "YES" fr diate referral to MH evalu						ion of Shift C	ommano	der and
Routi	ne Referral: Notify MH o	of any positive re	sponse to suicide	screen that o	lid not meet abov	e criteria for imr	nediate referr	al.	



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	Patient Name	nt Name Inmate Number Booking Number Date of Birth Toda				ay's Date		
					'			
		Р	SYCHIATRIC SCRI	EENING (Circle Y or N	l)			
1	History of or current List:	psychotropic meds?					Y	N
2.	History of psychiatri When?	c hospitalization?	Where'	?			Y	N
3.	History of outpatient When?	mental health treatmen	t? Where	?			Y	N
	JRRENT MENTAL ST	ATUS (Check all that a	pply) Thought Pro	cess:	Speech:			
	Alert, Oriented Disoriented	AppropriateFlatInappropriate	Logical Paranoid	make sense	Appropriate _Slurred _Pressured _Slowed Loud			
Mc	ood: _Appropriate _Depressed _Elated _Terrified/Crying _Angry	Activity / Behavior:AppropriateUnable to sit stillSlow / LethargicNo Eye contact	HallucinationVisualAuditoryTactileOlfactory	<u>-</u>				
oee	ave answered all ques en instructed and hav vide health care servi	stions fully. I have beer /e received information ces.	n instructed on and on sexual assault	received information on awareness. I hereby	how to obtain/access give my consent for 0	medic Correct	cal services Care Solu	. I havi
Pat	tient Signature:			Date:				



Date: _

Health Care Signature/Title: __



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date
REFERRALS: (check appropriate box)				
☐ Medical ProviderChronic CareSick CallCIWA/Withdrawal Protocol		alth blems – Immediate Refe roblems – (Current treatn disability)		
☐ Infection Control Nurse	☐ Dental			
PLACEMENT/HOUSING: (check appropriate	box)			
☐ General Population (GP) ☐ Medical Observational Housing ☐ Medical Isolation ☐ Mental Health Lockdown (if Mental Health ☐ Emergency Room for evaluation/treatmen ☐ Immediate placement on Suicide Precaut (If Mental Health not on-site)	t			



Health Center Intake Notice Disclosure of Medical Information



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

This is the beginning of your medical intake for the time you will be with the Department of Corrections. We want to make sure that you receive proper health care. In order to help us to ensure your proper care you need to be sure and tell us all of your medical history, medications, mental health history as well as your history of dental care. We need all the information from your past care as well as current care.

If you do not disclose complete and accurate information to the medical staff completing this intake, you could be putting yourself at risk.

We need to know about any medical conditions you have or have had in the past. We need to know any mental health services or residential facilities you have received services from. We will need the details about dental issues you have had or are having, including details about any treatment you have received. We need to know where you get your medications from, if you use more than one pharmacy, we need to know the names of all pharmacies that you use, along with the LOCATIONS of these pharmacies; this will expedite your getting medications you are currently prescribed to take.

If you have been in the hospital in the past year, provide the medical staff with as much information about the event, as possible.

If you feel that you are in need of mental health services, tell the medical staff performing this intake. They will complete a mental health referral for you. It is also important that you now let the medical staff know if you have a history of suicide, are thinking of hurting yourself and / or receive mental health services on the outside. You will need to tell the staff if you take any mental health medications.

Even if you believe someone on the outside has called this facility and shared your medical, mental health or dental needs; you must tell the medical staff at this time what the issues and needs are.

Inmate Signature / Date	Staff Signature / Date	





Brushing...Step by Step

Cepillarse lo dientes...Paso a paso

 Place toothbrush bristles at the gum line at a 45-degree angle to the gums. Press gently and use short strokes vibrating back and forth, or light scrubbing motion. Colocar las cerdas del cepillo de dientes en la línea de la encía formando un ángulo de 45-grados con las encías. Presionar suavemente y producir golpecitos que causen breves vibraciones hacia atrás y adelante o movimientos leves de cepillado.

Reposition brush vertically to clean inside upper and lower teeth.

Reubicar el cepillo de dientes de forma vertical para limpiar la superficie interior surfaces of front inferior y superior de los dientes frontales incisivos.

Start with upper teeth, brushing outside, inside, and chewing surfaces. Do the same for lower teeth. Be sure to brush each tooth. Comenzar con los dientes ubicados en la parte superior, cepillar las superficies externas, internas y las zonas en donde se produce la masticación. Repetir lo mismo con los dientes de la parte inferior. Asegúrese de cepillar cada diente.

To have fresh breath, brush the tongue too, since it can harbor many bacteria.

Para lograr un aliento fresco, también cepille la lengua, porque se pueden esconder muchas bacterias.

Dental Intake Screening



tient Name	Patient Number	Booking Number	Date of Birth	Today's Date
Please provide the following info	ormation (print cl	early):		
1. Are you having any denta	al pain now? (Circ	le one) YES	or NO (if no. sk	in to #7)
2. If yes, when did this start				P 10)
3. (Circle all that apply) Is it co	nstant? Does it co	me and go? Is it most	y when stimula	ted? (such as
when eating, brushing your tee		_	•	
Day or Night? Is it sharp?				
4. In which part of your mou	•	_	wer; Left or Rig	tht; Front or
5. Describe what has been ha		=1		
6. Have you had this same the				
7. When is the last time you				
a. Where did you rec	eive that care?	-		
b. What was done at	that time?			
8. Please note any additional	l information abou	ut your mouth that you	feel we should	know:
9. Nurses Clinical Observation	on			
Patient Signature:		Date:		
Vitness Signature:		Date:		
NOTES: (Please review the above, All o				STAFI
ntake completed by:			,	



Physician's Order



Patient Name		Inmate Number	Booking Number	Date of Birth	Today's Date
L		<u> </u>			
ALLERGIES:					
Physician:					
Date & Time:	may be dispensed un	drug identical in conte dess checked.	nt		
			III		
			_		
					=====



Health Services Discharge Planning



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

In order for us to be prepared for your release, please notify medical as soon as you become aware of the time of the release. By doing so, you will help us:

- 1. Prepare to give you a discharge summary
- 2. If you take medications, we can try to have them ready for you to take with you
- 3. If you need follow up care, we can prepare instructions
- 4. Answer any of your health related questions prior to your release

Please be certain that you tell a corrections officer that you need to stop by medical before you are released from the facility.

Inmate Signature/Date



Influenza Vaccine Consent Form



nt Name	Inmate Number	Booking Number	Date	of Birth	Today's Date
I have read the Vac Influenza Vaccine and regarding the Influen satisfaction. I believe and ask that Influenza	have been giv za Vaccine : I understand t	ven the oppo and they w he benefits a	rtunity t ere an	o ask qu swered	uestions to my
Please answer the follo	wing questions	:			
Have you ever had a seriou	ıs allergic reactior	n to eggs?	Yes	No 	
Have you ever had a seriou previous dose of influenza		n to a			_
Have you ever had Guillain	-Barre Syndrome	(GBS)?	· · · · · · · · · · · · · · · · · · ·	-	
Are you pregnant?			a	υ	
Are you nursing at the pres	ent time?		8 -	-	
Are you moderately or seve	rely ill at this time	?			
Inmate/Patient Signature			D	ate	
Vaccine administration date	:				x
Manufacturer:		Lot # _			
Site of injection:					



Signature and title of Vaccine Administrator

Inmate Blood Borne Pathogen Intake Education



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date		

The purpose of this information is to help you protect yourself from being exposed to blood borne pathogens.

Jails and prisons have an increased amount of HIV and Hepatitis. You can contract blood borne pathogens by being exposed to blood and body fluids: urine, feces, semen, etc. In general, any body fluid should be considered contaminated.

If you have to clean a cell, bathroom, do laundry, clean booking, or any other area which potentially has body fluid (including that which you cannot see), you should wear protective items such as: goggles, gloves, disposable gowns, face / spit shields, to reduce your risk of exposure. If there are blood spills on a floor, there are special spill kits in the health center that need to be used.

All of the above mentioned items are in the facility for inmate workers and or any inmate cleaning areas that could expose you. You can ask medical and or a correctional officer to get these items for you.

If you are exposed to blood or body fluids, you should report this to the security supervisor and medical immediately. An example of an exposure would be blood being splashed into your eye(s).

Washing your hands for 60 seconds, with warm water and soap after completing any task is a great way to prevent / limit exposure. In this environment, all inmates should wash their hands several times throughout each day, as a precautionary measure – regardless of working or task(s). If soap and water are not readily available, there is plenty of waterless hand sanitizer available for use.

If you have any further questions regarding blood borne pathogens, please ask a medical staff member.

Inmate Signature / Date





Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

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ANSWERS TO QUESTIONS YOU MAY HAVE ABOUT WHAT YOU CAN -- AND CAN'T -EXPECT FROM THE MEDICAL DEPARTMENT

What health screening takes place when I arrive at a facility?

A nurse will review your health status when you arrive. It is important that you let us know about any medical, mental health, or dental condition you are being treated for. If your regular doctor has records which we can use, please let us know. You will be asked to sign the necessary permission for us to have copies.

A tuberculosis skin test is done on admission. Please let us know if you have had a positive test before. Later, you will meet with a provider for a further review of your medical history and physical examination.

How do I request medical attention?

Fill in a sick call slip. They can be obtained from your unit officer and are picked up regularly by medical department staff. State in a few words why you want to be seen. You don't need to go into details. Your unit officer or caseworker will assist you if writing the slip is a problem for you. You can keep the yellow copy of the slip for your own records if you wish.

Who will see me in the medical department?

Medical staff includes nurse's aides (LNA's), nurses (LPN's and RN's), and providers, who may be nurse practitioners, physician's assistants, or physicians. A nurse can work out many problems, and that will get them taken care of most quickly. Providers are available regularly but do not work full time, so there may be a longer wait for a provider visit. Please do not ask to be scheduled with a particular provider. We work together and try to coordinate our efforts for you, and we cannot make anyone a private patient of any one provider. This applies even if — as sometimes happens — you have been cared for by one of us in the community.

When and where do I get medication?

Location of medication administration will vary from site to site. You will be given site-specific instructions regarding medication administration times and locations at the time of your intake. This information is also posted in the living units. If a medication has been prescribed to take regularly and you do not want to take it, you will be asked to sign a form stating your refusal. If the order is for use "as needed" (the medical term for this is "p.r.n."), you still must take the medication at a med-line time. You should tell the nurse if you feel you need your p.r.n. medication; if you do not take it, you will not have to sign a refusal for it. There must be an order from a provider for any medication you receive.

Can I get a supply of my medication so I don't have to line up to get each dose?

Ordinarily no. Nitroglycerine for heart problems is provided three pills at a time. A few other medicines might be given out to self-carry.





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What about an emergency?

Notify your unit officer. Medical staff is available in each facility 24/7. Arrangements will be made for you to be seen at a nearby hospital emergency room if there is an emergency which can't wait until a suitable provider is at your facility, or equipment and skills are needed that are not available at the facility.

Can lab tests and x-rays be obtained here?

Yes. Specimens for Lab tests can be obtained at each facility and sent to a Lab. Some facilities have onsite x-ray capability. If your facility does not have this capability, your x-ray, as well as any more elaborate tests ordered, may require a trip to a hospital or elsewhere.

What if I need to be seen by a specialist elsewhere?

The facility provider will arrange for visits to outside specialists if they are needed. For security reasons, we cannot tell you when an upcoming outside appointment is scheduled.

Can I get medical screening tests done?

Many routine screening tests can be done here. These include tests for HIV (the AIDS virus), hepatitis C, syphilis, high cholesterol, and diabetes, among others. Skin testing for tuberculosis is required when you arrive at a facility.

Will I get the medicines I was taking before coming here?

Unless our provider determines otherwise, verified community prescriptions will be continued upon arrival until a provider sees you.

Why would my medication be substituted?

Just like Medicare and most health insurance plans, we have a *formulary*, which is a list of the medications preferred. What you are used to taking may or may not be on our formulary list. If there is good medical reason to depart from the formulary list you may get medication not on the list.

How long will it be between the time I see the provider and the time I get the medication he or she has ordered?

Ordinarily a day or two. Urgent or Emergent medications can be obtained in an expedited fashion should this be required.

Can I get a copy of my medical record?

If your attorney needs a copy of your record, he or she can obtain it by filing a request with the Department of Corrections. The medical department does not make copies of records to give directly to inmates or others. You have a right to see your record and review it with medical staff. You must make an appointment to do so.





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How do I file a grievance if I don't think I have had proper medical attention?

Grievance forms are available from your housing unit officer. They should be submitted through the facility administration. They will be logged and investigated. You should have a written response within 14 days of submitting the form. If you are not satisfied with the response, you may file a Level Three grievance. These will be assigned to the Inmate Advocate for resolution, if necessary. Copy of grievance process is on file in library.

Will you order a special diet for me?

Special diets are available for patients whose verified medical condition requires such a diet.

How do I get to see a dentist?

File a sick call slip about your need for a dental visit. A nurse will evaluate your request and you will be placed on the Dental list.

Can I get my eyes checked or get glasses if I need them?

There is an optometrist in the facility regularly. A sick call slip specifically asking for this service will get you on the list. Glasses are provided for those who need them and do not have them.

Can I get a Low bunk pass, extra pillow or extra mattress?

These items are available if our medical provider determines that you have a medical condition which requires them.

Can I obtain condoms?

Condoms are available upon request from the medical department.

TYPES OF MEDICINE AND TREATMENT

What sorts of pain medications can I expect to get?

Like any medical decision, choice of pain medication takes various factors about you and your problem into account. We use a lot of caution in prescribing powerful pain medications, including many of the ones, which are often used in the community. The medicines we do prescribe are effective for most problems, which cause pain, but a perfectly safe and effective pain pill has never been invented.

Are psychiatric medicines handled differently?

Psychiatric staff prescribes them, and they have a separate formulary and rules. Mental health staff and medical staff cooperate very closely at all facilities.





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Whom do I ask about getting a sleeping pill?

You will need an evaluation and appt to discuss options for helping you to sleep better.

Can I continue a buprenorphine (Suboxone*) program while at a correctional facility?

Vermont Department of Corrections policy may permit you to continue buprenorphine during an incarceration of thirty days or less. Many factors determine if you will be eligible to continue your suboxone. If you are not eligible to continue on Suboxone, we will work with you on detox efforts while you are here.

Can I get nicotine patches to help with not having cigarettes?

For security reasons, they are not available. The enforced smoking cessation, which comes with incarceration in Vermont, may be uncomfortable, but people actually manage it fairly well.

Can I get supplemental vitamins?

They are available when there is a good medical reason to need them. You can order vitamin supplements from the commissary if you wish.

What about herbal supplements and natural products?

Most of the things sold in these categories are not on our formulary and would not be available unless a strong medical case can be made for needing them.

Received by:	
Inmate Signature:	Date:



Medical Disposition Change Request



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date
Department (Circle)		=		
Medical	Mental Health	Den	tal	Other
M Level Request (Ci	rcle)			
M1	M2	М3	M4	
Reason For Request	:			
,				
,				
Requested By:				
Signature:				
Date Request Received_				
Date change Implemente	ed/Initials			



Medication Verification/Medical Release Form Authorization for Release of Medical Information



Patient Name	In	mate Number		Date of Birth	Today's Date
AKA(Alias):	Be	ooking Number			Social Security No:
I Authorize:			To Release	Information :	To:
Name of organization or individ	dual			ect Care So	
Address			Address:		
Fax #:		1	l .		
For the following purpose (state reason for requ	est):			
☐ Medical Record Lab Tests (And I authorize this release knowly includes any and all alcohol at testing, results or treatment. Tundersigned will hold the compact Autorizo esta divulgación condicha información. Esto abardesto comprende toda informalguna la persona o institución sociedad, sus empleados, age This authorization expired Signature of Resident or (Proof is required for legal guarante de la particular	Todas las historias cl ds (Historias clínicas mé disis de laboratorio) ing that the confidential and/or drug abuse treat The above named perso pany, its employees, agu n conocimiento de que le ca todos los registros de ación relacionada con le n que se nombra arriba entes y contratistas que es Legal Guardian ardian) BENCY RECEIVING INF	Inicas) dicas) □ Me dicas) □ Me lity of the informment records on or agency _a ents and contra a legislación o o e tratamiento co os análisis de junto con sus r den cumplimier	ental Health Recoredications (Medical mation may be proposed propo	inmentos) Difference of the complying with the complex product of the comple	n velar por el carácter confidencial de a o registros psiquiátricos. Asimismo, se. Queda exenta de responsabilidad rmante exime de responsabilidad a la ación.
The following medications I	have been <u>verified</u> fo	r the above pa	atient:		
Medication name and strength	dose, frequency and s	top date	Date las	filled: Qty:	Prescribing Provider:
				# refills:	
Medication name and strength	dose, frequency and s	top date	Date las	filled: Qty:	Prescribing Provider:
				# refills:	
Medication name and strength	dose, frequency and s	top date	Date last	filled: Qty:	Prescribing Provider:
				# refills:	
Medication name and strength	dose, frequency and s	top date	Date las	filled: Qty:	Prescribing Provider:
				# refills:	
Medication name and strength	dose, frequency and s	top date	Date las	filled: Qty:	Prescribing Provider.
				# refills:	
Pharmacist's name: Nurse Signature:	ş t.				ate:
_	·				-
Physician Signature:				Da	ate:



VERMONT DEPARTMENT OF CORRECTIONS OFFENDER/INMATE ORIENTATION TO ADA

If you have a disability (*defined below*), you have the right to request *reasonable accommodations* in order to make programs and services you are receiving, or will receive, more accessible and usable to you. Under the ADA, an individual with a disability is a person who has:

- A physical or mental impairment that substantially limits one or more major life activities, such as: walking, talking, hearing, seeing, caring for oneself, or working;
- > A record of such impairment; or
- > Is regarded as having such an impairment.

A reasonable accommodation is any change in the environment or the way in which tasks are completed that allows you to participate in the program or service. Accommodating a disability is always evaluated in the context of it not being an undue burden on the Department, not jeopardizing safety or security, or not resulting in a fundamental alteration in the nature of a program or activity. A qualified individual with a disability is a person with a disability who, with the assistance of a reasonable accommodation, is able to meet the essential eligibility requirements for the receipt of services or the participation in programs or activities.

How to Ask for a Reasonable Accommodation

If you want or need a reasonable accommodation, ask any staff for a form to fill out (*Request for Reasonable Accommodation*). Fill out the Request Section of the form, sign, and date it. If you need help filling it out, ask a staff person. Your request will be reviewed and responded to within ten (10) business days after staff receipt of the request (unless a medical or other evaluation is needed to make a decision about the need for the accommodation). You will receive the decision in writing.

How to Make Complaints/Seek Review

If your request for accommodation is denied or modified by the Department's ADA Director, or you disagree with the decision, you have the right to file an appeal to the Commissioner by filling out the *ADA Decision Appeal to Commissioner Form* which any staff can give you. If you believe you were discriminated against because of your disability, you may file a formal grievance per *Department Directive #320.01*, *Offender Grievance System*.

	oriented & understand your rights under the America
· · · · · · · · · · · · · · · · · · ·	ervision of the Vermont Department of Corrections.
At this time I do not request a reasonable acco	ommodation.
Offender/Inmate Printed Name (above)	
Offender/Inniate Finited Name (above)	
Offender/Inmate Signature (above)	Date:
Staff Signature:	Date:
If you do want an accommodation, check and	sign below:
I request a reasonable accommodation.	have been given a Request Form to complete.
Offender/Inmate Signature (above)	Date:
Staff Signature:	Date:

Problem List



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date
Date Identified	Chronic (Long	Term) Problems	Treatn	nent Plan
	, ,			
	<u></u>			
1	emporary (Usually	Self-Limiting) Problem	ns	
Problem		Date of Ea	ch Occurrence	
Allergies:		ecord □ Previous Posit		
Planted: Initials: L	ocation:	Read:	Results:	_ Initials:
Lot # Expiration:		CXR □		
□ PPD Testing Pamphlet		Ordered:	_ Completed:	Results:
☐ PPD Skin Test Refused and Refusal Fo	rm Signed			
☐ PPD Skin Test NOT APPLIED due to:				
ANNUAL - PPD TEST				
Planted: Initials: L	ocation:	Read:	Results:	_ Initials:
Lot #Expiration:		CXR □		
		Ordered:	_ Completed:	Results:
ANNUAL - PPD TEST				
Planted: Initials: L	ocation:	Read:	Results:	_ Initials:
Lot # Expiration:		CXR □		-
		Ordered:	_ Completed:	Results:



Progress Note



Patient Name		Inmate Number	Booking Number	Date of Birth	Today's Date
ALLERGI	ES				
Time	Comments:				
				=	



Patient Name

Receipt of Intake Packet



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

I have reviewed and received the intake packet from this facility. I have received copies of the following documents:

- 1. Brushing Step by Step
- Health Services Discharge Planning
 Inmate Guide to Medical Services
- 4. Offender/Inmate Orientation to ADA
- 5. Sexual Assault Awareness for Offenders

nmate Signature:	Date:
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Refusal of Treatment



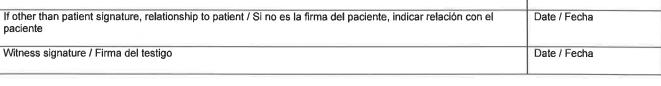
Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date
I,(Name of Patient)		have, this day, knowing	g that I have a	condition requiring
(Name of Patient)				
medical care as indicated below:				
A. Refused medication		E. Refuse	d X-Ray servic	e
B. Refused dental care		F. Refused	d other diagno	sis services
C. Refused an outside medical	appointment	G. Refuse	d physical exa	m
D. Refused laboratory services		H. Other (Please specify)
Reason for Refusal				
				-
Potential Consequences Explained:				
A. Worsening Of Medical Cond	ditions	C. Permar	ent Disability	
B. Death		D. Other_		
I acknowledge that I have been fully involved in refusing. I hereby release responsibility and any ill effects which	and agree to l	nold harmless CCS an		
I have read th	is form and certi	fy that I understand its	contents.	
Witness Signature				
Witness Signature	Pa	tient Signature		
		me		



Authorization for Release of Information Autorizacion para divular informacion



Patient Name	Patient Number		Date of Birth	Toa	lay's Date	
AKA(Alias):	Booking Number	Booking Number		Soc	ial Security No:	
Authorize / Autorizo: Name of organization or individual / Nomb	ro		ease Information To / A		Información a:	
				iorribre		
Address / Dirección		Address / Dirección				
1 This authorization includes records relacionados con lo que se detalla				omprende	los registros	
☐ All remaining records / Otro ☐ Mental health treatment / Tr ☐ Chemical dependency treat ☐ HIV or AIDS related tests a	atamiento de salud mental ment / Tratamiento de drogadi	cción o alc				
2 Purpose for disclosure (this line m	ust be completed) / Propósito o	le la divulo	ación (se debe completar e	este rengló	n):	
3. Indicate dates of interest / Indique I If no date-range is provided, releas sólo por el término del año anterior	e will cover the previous year of	only / Si no	se indica el periodo de div	ulgación, la	a misma tendrá lugar	
 I understand that I may revoke thi by providing written notice, except information has already occurred in 	to the extent that release of	4.	Comprendo que puedo n cualquier momento siem escrito, salvo que la divu efectuado dependiendo de	pre que n Ilgación de	notifique mi decisión por mi información se haya	
 I understand that under Federal La relating to treatment for chemica released without my specific author "1." 	al dependency cannot be	5.	 Comprendo que conforme a la Ley Federal (42CFR – Cóc de Normativa Federal – Parte 2) los registros relaciona con el tratamiento para el alcoholismo o drogadicción pueden divulgarse sin mi previa autorización especifica como indica el punto "1." 			
 I understand that information authorization may not be disclos without my approval other than a federal laws. 	ed again by the recipient	6.	 Entiendo que la información que se divulgue en relación a autorización no puede ser revelada nuevamente por la pa receptora de la misma sin mi debida aprobación tal como indican las leyes estatales y federales. 			
 I understand that I will receive tre provide approval, but also und authorize information may affect the provided. 	erstand that refusing to	7.	 Comprendo que recibiré tratamiento incluso si me niego a otorgar mi aprobación; pero, asimismo comprendo que rehusarme a autorizar la divulgación de mi información pueda afectar la naturaleza del tratamiento que se me proporcione. 			
 I agree to hold harmless all p authorization in good faith. 	persons acting upon this	8.	 Acepto eximir de responsabilidad a todas las personas qu actúen con buena fe bajo la presente autorización. 			
 It is my intention that a photocop original. 	by will be as valid as this	9.	Manifiesto que una fotoc copia original.	opia tendra	á el mismo valor que su	
0. This authorization shall be valid for of my signature.	or one year from the date	10.	La presente autorización año a partir de la fecha o			
Patient or authorized signature / Fir	ma del paciente o persona aut	orizada			Date / Fecha	





Sexual Assault Awareness for Offenders



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date
		5		

1

Sexual Assault Facts:

- 1. Rapists can be male or female.
- 2. Sexual orientation (preference) is not necessarily a factor as it relates to sexual assault. A rapist may be heterosexual or homosexual. The victim of a sexual assault may also be heterosexual or homosexual. Many rapists report being in a relationship, including marriage, at the time of the rape.
- 3. Any male or female can be sexually assaulted.
- 4. Physical attractiveness is not a factor regarding sexual assault.
- 5. Age is not a factor concerning sexual assault. Sexual assault, to include rape, happens to females and males of all ages.
- 6. Statistics indicate one out of ten male offenders and one out of every four female offenders who are incarcerated have experienced some form of pressured or forced sexual contact during their incarceration. Many rapes often go unreported.
- 7. No one "asks to be assaulted." Victims of assault, including rape, are not at fault. Sexual assault is a crime of violence and does not relate to love, lust or passion.
- 8. Rapists often commit the act to assert their strength, dominance and need for control. They rape to degrade and humiliate their victims, often preying on those that are weaker in nature.

Offenders that have the potential for being sexually aggressive include those who:

- 1. are between the ages of 27 and 45.
- 2. are medium to large build as well as possess physical strength.
- 3. are aggressive in nature, often are established in the hierarchy of the correctional setting by their strength and power.
- 4. have limited ties to outside family and friends and have little or no outside means of financial support.
- 5. are accustomed to being incarcerated, often doing a long sentence.
- 6. are incarcerated for violent offences.
- 7. are incarcerated for sexual offences.
- 8. are more streetwise and gang affiliated.

Offenders that are potentially at risk for being preyed upon or targeted as a victim include those who:

- 1. are between 16 to 26 years of age.
- 2. are incarcerated for the first time.
- 3. are viewed as having "feminine" characteristics.
- 4. appear passive, timid or weak in nature.
- 5. have a small build and are not strong in appearance.
- 6. are well connected to outside family and friends and have means of outside financial support.
- 7. are identified as homosexual or have a history of being previously assaulted or raped.
- 8. have been convicted of sexual offences against a minor.

Tips for avoiding sexual assault include:

- 1. Trust your instincts. If you are in a situation that makes you feel uncomfortable, leave.
- 2. Avoid isolated areas when possible; try to stay within view of correctional staff.
- 3. Do not accept favors, to include food, cigarettes, or commissary items from another offender. You may be expected to "repay" your debt with sexual favors or acts.
- 4. Be aware of offenders who promise protection, as they often expect sexual favors in return.
- 5. Do not give out information about your financial support system, to include your support system of family and friends.
- 6. Avoid purchasing large amounts of commissary, as this gives the impression you have money available to you.
- 7. Walk and stand with confidence. Stand tall and avoid looking away or down. Don't be afraid to say "NO."
- 8. Avoid engaging in conversation about casual nudity or sex, as this may be considered a come on and lead another offender to believe you may have interest in a sexual relationship.



Sexual Assault Awareness for Offenders



Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

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Reporting Sexual Assault:

- If you are being intimidated or are in fear of a sexual assault, immediately report this to any staff member to whom you
 feel comfortable reporting the information.
- 2. If you are a victim of a sexual assault or rape, report this to any staff member immediately. The longer you wait the more difficult it is to obtain the evidence necessary for an administrative/criminal investigation. Do not shower, brush your teeth, use the bathroom or change your clothes. By doing so, you could destroy important evidence such as hair, saliva, semen or clothing fibers that could assist in the investigation. Remember, any sexual contact significantly increases your risk of contracting a sexually transmitted disease, to include HIV. By reporting the incident immediately, you decrease your chances of getting these diseases.
- 3. If you are a victim and report a sexual assault incident, you will be evaluated by health services and have appropriate treatment provided. In addition, you will be referred to mental health services for an evaluation, as victims of sexual assault may experience feelings of self-loathing, anger, rage, humiliation, nightmares, depression, and isolation.

Staff Misconduct

Sexual conduct between staff and offenders, visitors and offenders or contract personnel and offenders is prohibited and
is subject to administrative and criminal disciplinary action. You should report staff misconduct immediately, to anyone you
feel comfortable reporting the information to. You may also report the incident to internal affairs via your attorney, a friend
or family member, or through the internal mail system. You will be protected from retaliation.

Received by:	
Inmate Signature:	Date:



Staff Referral Form



tient Name	Patient Number	Booking Number		Date of Birth	Today's Date	
Type: ☐ Urgent ☐ I	Routine					
Medical	<u>Dental</u>	į	Mental	Health		
☐ Physician	☐ Dentist	1	□ Psyc	hiatric Provi	der	
☐ Mid-level Provider		1	□ мн г	Professional		
□ Nurse		1	☐ MH Nurse			
☐ Chronic Care Asthma COPD/F Hypertension HIV / AI	Pulmonary Car DS Pre	diac _ gnancy _	Diabet Seizur	es	NID Diabetic Other (noted below)	
□ Other						
Referred By:				a		
Printed Name	Signatu	ıre		Date		
Appointment Date:	<u>;</u>	Date S	een: _			
Seen By:						
Printed Name	Signatu	ıre		/ Date		

